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8100 Blueprint for Health (03/05/2011, 10-19)

The General Assembly of the State of Vermont, in enacting Act 191 (2005), created the Blueprint for Health.

The Blueprint for Health (Blueprint) is the State of Vermont's program for integrating a system of health care for patients, improving the health of the overall population, and improving control over health care costs by promoting health maintenance, prevention, and care coordination and management.

The Blueprint for Health resides in the Agency of Human Services (AHS), Department of Vermont Health Access (DVHA).

DVHA shall periodically publish a Blueprint for Health Manual. Changes to the Manual shall only be made after a thorough public process for comment, discussion, and consensus building. That public input process shall include an internet posting of draft revisions to the Manual, distribution of the draft to the Expansion Design and Evaluation Committee, the Blueprint Executive Committee, and the Payer Implementation Work Group and discussion of proposed Manual revisions in a minimum of two meetings of the Expansion Design and Evaluation Committee. Written and oral comments on proposed Manual revisions may be submitted to the Department.

8101 Governance (03/05/2011, 10-19)

The Blueprint Director oversees development and implementation of the Blueprint for Health under the direction and responsibility of the Commissioner of the Department of Vermont Health Access (DVHA) in collaboration with the Commissioner of the Department of Health.

The Health Care Reform Director supports development and implementation of the Blueprint for Health in collaboration with the Blueprint Director and oversees state health reform initiatives, including Health Information Technology (HIT), under the direction and responsibility of the Commissioner of the Department of Vermont Health Access (DVHA).

8101.1 Advisory Groups (03/05/2011, 10-19)

Three groups serve in an advisory capacity to the Blueprint Director:

A. The Blueprint Executive Committee advised on the Blueprint's broad strategic planning.

B. The Expansion Design & Evaluation Committee advises on the Blueprint's expanded implementation.

C. The Payer Implementation Work Group Advises on the technical details of payment implementation and modifications.

The Advisory groups are described in the Blueprint for Health Manual.

8102 Medical Home Requirements (03/05/2011, 10-19)

Any physically-based Vermont physician, nurse practitioner, or physician assistant practice site, that is subject to Vermont law, and is providing general primary care services to its patient panel through the oversight of a general practice, family medicine, internal medicine, obstetrics and gynecology (OB/GYN), or pediatric medicine professional may be eligible to participate as a Blueprint Medical Home.

Upon request, practices are required to demonstrate that their principle focus is delivery of primary care by producing an annual summary of paid claims billing codes that indicate the majority of patient records include services that are billed under the Current Procedural Terminology (CPT) Evaluation and Management (E&M) codes (99201-99350) typically recognized by public and private insurers for primary care services.

A health care professional or practice providing a patient's medical home shall be engaged in processes to implement elements of the Medical Home to:

A. provide comprehensive prevention and disease screening for his/her patients and managing his/her patients' chronic conditions by coordinating care;

B. enable patients to have access to personal health information through a secure medium, such as through the Internet, consistent with federal health information technology standards;

C. use a uniform assessment tool of the Medical Home's choice to assess the health of all patients;

D. collaborate with the community health teams, including by developing and implementing a comprehensive plan for participating patients;

E. ensure access to a patient's medical record(s) by the Community Health Team (CHT) members in a manner compliant with federal and state law; and

F. meet regularly with the CHT to ensure integration of a participating patient's care.

8102.1 Application, Eligibility/Enrollment and Certification (03/05/2011, 10-19)

The Blueprint utilizes the National Committee for Quality Assurance (NCQA) standards for Physician Practice Connections – Patient Centered Medical Home (PPC-PCMH) model to evaluate and score practices to become and maintain their status as recognized Blueprint Medical Homes.

A general practice, family medicine, internal medicine, OB/GYN, or pediatric practice must achieve official recognition as an NCQA Patient Centered Medical Home to be eligible to participate as a Blueprint Medical Home.

The Blueprint for Health Manual describes the Blueprint Medical Home application, eligibility/enrollment and recognition process. Changes to the Manual shall only be made as described in Rule 7800.

Medical Home Requirements

8102.2 Reimbursement (03/05/2011, 10-19)

Reimbursement is described in the Blueprint for Health Manual. Changes to the Manual shall only be made as described in Rule 7800. Reimbursement to Medical Homes from participating insurers and the Department of Vermont Health Access (DVHA) includes a per-person per-month payment to the Medical Homes for their attributed patients and payment to the administrative entity in each Hospital Service Area for the shared costs of operating the Community Health Teams. A lead administrative entity shall be an organization recognized as an eligible Medicare provider. The lead administrative entity can hire Community Health Team members and / or distribute funds to other entities in the community to hire Community Health Team members. The Community Health Team members will be dedicated to supporting all recognized Medical Homes and their patients, and the goal of creating communities of well coordinated holistic health services.

8102.3 Health Information Technology Standards (03/05/2011, 10-19)

Medical Homes must meet minimum standards for the adoption, implementation, and deployment of health information technology (HIT). The core HIT standards are:

A. Completion of signed agreement(s) with Vermont Information Technology Leaders, Inc. (VITL) for health information exchange (HIE) via the statewide Health Information Exchange (HIE) network.

B. Adoption of HIT patient privacy and security policies consistent with the Vermont Health Information Technology Plan.

C. Documentation of practice site Electronic Health Record (EHR) adoption and implementation with an EHR system that can exchange bi-directional, structured data with the Blueprint Registry or demonstration that the practice can meet the requirements of either of the following:

1. If a practice site has not implemented an EHR, documentation of its planning process and the timeline for EHR adoption and implementation, and a demonstrated commitment to utilizing the web-based Blueprint Registry tool until the practice implements an EHR.

2. If a practice does not plan to implement an EHR, documentation of its demonstrated commitment to utilizing the web-based Blueprint Registry tool.

Vermont Information Technology Leaders (VITL) serves as the state's HIT Regional Extension Center (REC) with state and federal funding that may assist practices in ensuring connectivity between EHR systems and the Blueprint HIT infrastructure, including the Blueprint Registry.

8103 Community Health Team(s) Requirements (03/05/2011, 10-19)

The Community Health Teams (CHT) are multi-disciplinary teams developed at the local level to meet the specific needs of each community. Examples of CHT members include but are not limited to: nurses, care coordinators, social workers, counselors, health educators, nutrition specialists, community health workers and other public health professionals, pharmacists, chiropractic physicians, dentists, dental hygienists and other dental professionals, physical therapists, speech therapists, occupational therapists and other health care professionals from multiple disciplines.

Health care professionals participating on a CHT:

A. Collaborate with other health care professionals and with existing state agencies and community-based organizations to coordinate disease prevention, manage chronic disease, coordinate social services if appropriate, and provide an appropriate transition of patients between health care professionals or providers. Priority may be given to patients willing to participate in prevention activities or patients with chronic diseases or conditions identified by the Blueprint Director.

B. Support a health care professional or practice which operates as a medical home by:

1. assisting in the development and implementation of a comprehensive care plan for a patient that integrates clinical services with prevention and health promotion services available in the community and with relevant services provided by the agency of human services.

2. providing a method for health care professionals, patients, caregivers, and authorized representatives to assist in the design and oversight of the comprehensive care plan for the patient;

3. coordinating access to high-quality, cost-effective, culturally appropriate, and patient- and family-centered health care and social services, including preventive services, activities which promote health, appropriate specialty care, inpatient services, medication management services provided by a pharmacist, and appropriate complementary and alternative (CAM) services;

4. providing support for treatment planning, monitoring the patient's health outcomes and resource use, sharing information, assisting patients in making treatment decisions, avoiding duplication of services, and engaging in other approaches intended to improve the quality and value of health services;

5. assisting in the collection and reporting of data to evaluate the Blueprint model on patient outcomes, including collection of data on patient experience of care, and identification of areas for improvement; and

6. providing a coordinated system of early identification and referral for children at risk for developmental or behavioral problems such as through the use of health information technology or other means as determined by the Blueprint Director.

C. Provide care management and support when a patient moves to a new setting for care by:

1. providing on-site visits from a member of the CHT, assisting with the development of transition plans and medication reconciliation upon admission to and discharge from the hospital, nursing home, or other institution setting;

2. generally assisting health care professionals, patients, caregivers, and authorized representatives in discharge planning, by assuring that post discharge care plans include medication management as appropriate;

3. referring patients as appropriate for mental and behavioral health services;

4. ensuring that when a patient becomes an adult, his or her health care needs are provided for; and

5. serving as a liaison to community prevention and treatment programs.

D. As applicable, interact with:

1. The Department of Vermont Health Access Care (DVHA) Chronic Care Program for Medicaid beneficiaries, programs focused on Medicare or dually-eligible beneficiaries such as the Seniors Aging Safely at Home (SASH) program, and other programs supporting the populations served by Vermont's Choices for Care Medicaid waiver.

2. Department of Health District Director or designee for support of public health initiatives and coordination with specific health department initiatives.

3. State and regional staff of the Agency of Human Services (AHS) who work on programs targeting specific sub-populations within the community the CHT serves.

8103.1 Application and Designation (03/05/2011, 10-19)

The Blueprint for Health Manual describes the application and designation process. Changes to the Manual shall only be made as described in Rule 7800.

8104 Health Insurer Requirements (03/05/2011, 10-19)

No later than January 1, 2011, health insurers shall participate ("participating insurer") in the Blueprint for Health as a condition of doing business in the State of Vermont. Health insurance plans shall be consistent with the Blueprint for Health as determined by the Commissioner of the Department of Banking, Insurance, Securities, and Health Care Administration (BISHCA).

"Participating insurer" means a health insurance plan as defined in 18 V.S.A. § 706.

"Participation" in the Blueprint for Health means a health insurer shall provide reimbursement to all recognized Blueprint Medical Homes and designated Community Health Teams.

The BISHCA Commissioner may exclude or limit the participation of health insurers offering a stand-alone dental plan or specific disease or other limited benefit coverage in the Blueprint for Health. Health insurers shall be exempt from participation if the insurer only offers benefit plans which are paid directly to the individual insured or the insured's assigned beneficiaries and for which the amount of the benefit is not based upon potential medical costs or actual costs incurred.

8104.1 Reimbursement to Medical Homes (03/05/2011, 10-19)

Participating insurers will be notified of the new (recognized) Medical Home(s) and will have 30 calendar days to produce listings of patients attributed to the practice and supply the list to the Medical Home (or its designee).

Reimbursement is described in the Blueprint for Health Manual. Reimbursement to Medical Homes from participating insurers and the Department of Vermont Health Access (DVHA) includes a per-person per-month payment to the Medical Homes for their attributed patients and payment to the administrative entity in each Hospital Service Area for the shared costs of operating the Community Health Teams. Changes to the Manual shall only be made as described in Rule 7800.

8104.2 Appeal (03/05/2011, 10-19)

An insurer may appeal a decision by the Blueprint Director to require a particular payment methodology or payment amount to the Department of Vermont Health Access (DVHA) Commissioner, who shall provide a hearing in accordance with Chapter 25 of Title 3. An insurer aggrieved by the decision of the DVHA Commissioner may appeal to the superior court for the Washington district within 30 days after the Commissioner issues the decision.

8105 Hospital Requirements (03/05/2011, 10-19)

A. No later than July 1, 2011, physically-based Vermont hospitals, subject to Vermont law, shall participate in the Blueprint for Health by establishing and/or maintaining connectivity to the state's health information exchange (HIE) network. Hospitals participation in the HIE shall conform to the strategic and operational goals included in the most recent version of the Vermont Health Information Technology Plan.

B. By July 1 each year, establish and maintain the criteria for the exchange of health information to support the Blueprint for Health information technology infrastructure and the Blueprint Registry as published by the Health Care Reform Director pursuant to Blueprint for Health rule 7805.1 B.

A hospital is not required to create a level of connectivity that the state's HIE is not able to support. The certification process, including the appeal process (Blueprint for Health rule 7805.2), shall be completed prior to the hospital budget review.

8105.1 Health Care Reform Director Responsibilities (03/05/2011, 10-19)

The Health Care Reform Director or designee shall:

A. ensure hospitals have access to state and federal resources to support connectivity to the state's HIE network.

B. beginning January 15, 2011 and annually thereafter, publish a list of specific criteria each hospital must establish and maintain for the exchange of health information to support the Blueprint for Health information technology infrastructure and the Blueprint Registry.

C. establish a process for annually certifying that a hospital meets the participation requirements.

D. waive further certification once a hospital is fully connected to the state's HIE.

E. provide the hospital with documentation to include in its annual budget review once the hospital has been certified or certification has been waived.

The Health Care Reform Director may require a hospital to resume certification if the criteria for connectivity change, if the hospital loses connectivity to the state's HIE, or for another reason which results in the hospital not meeting participation requirements.

8105.2 Appeal (03/05/2011, 10-19)

A denial of certification by the Health Care Reform Director or designee may be appealed to the Department of Vermont Health Access (DVHA) Commissioner, who shall provide a hearing in accordance with chapter 25 of Title 3. A hospital aggrieved by the decision of the DVHA Commissioner may appeal to the superior court for the district in which the hospital is located within 30 days after the Commissioner issues the decision.